

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

The External Review of Hospital Quality

The Role of Accreditation



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EXECUTIVE SUMMARY

PURPOSE

To assess the role of Joint Commission accreditation in the external review of hospital quality.

BACKGROUND

External Quality Review of Hospitals in the Medicare Program

Hospitals routinely offer valuable services, but also are places where poor care can lead to unnecessary harm. The external quality review of hospitals plays an important role not only in protecting patients from such harm, but also in complementing the hospitals' own internal quality efforts. The Federal Government relies on two types of external review to ensure that hospitals meet the minimum requirements for participating in Medicare: accreditation, usually by the Joint Commission on Accreditation of Healthcare Organizations, and Medicare certification, by State agencies. About 80 percent of the 6,200 hospitals that participate in Medicare are accredited by the Joint Commission.

This Inquiry

This report, part of a series of four companion reports that resulted from our inquiry, focuses on the Joint Commission because it dominates the hospital accreditation market. Our inquiry draws on aggregate data, file reviews, surveys, and observations from a rich variety of sources, including HCFA, the Joint Commission, State agencies, and other stakeholders.

We organize this report around a framework we developed for considering the external review of hospital quality. This framework consists of five components: announced, on-site surveys of hospitals; unannounced, on-site surveys of hospitals; responses to complaints concerning hospitals; responses to major adverse events in hospitals; and collection and dissemination of standardized performance measures.

FINDINGS

ANNOUNCED SURVEYS

Joint Commission surveys are undertaken in a collegial manner and are tightly structured. This approach fosters consistency but leaves little room for probing.

Surveys look the same hospital to hospital. Surveyors are well-versed in the Joint Commission standards and aim to educate the hospital staff about the significance and intent of those standards. To get an overview of the hospital, the surveyors maintain a rapid pace with survey sessions scheduled back-to-back, leaving little opportunity for following up leads or developing hunches.

Joint Commission surveys serve as a means of both reducing risk and fostering attention to continuous quality improvement, but are unlikely to either surface substandard care or identify individual practitioners whose judgement or skills to practice medicine are questionable.

Hospitals take Joint Commission surveys seriously. The surveys prompt their attention to minimum protections that are important to patients and promote projects aimed at improvement. But surveyors lack much background information on the hospital that could help them hone their survey, thus they get a broad rather than in-depth view of the hospital. This, coupled with the tight structure, make it unlikely that the survey will identify patterns or instances of poor care.

While they matter enormously to hospitals, Joint Commission survey results fail to make meaningful distinctions among hospitals.

Hospitals attach great significance to survey results and use them as a way of distinguishing themselves from other hospitals. However, the distinction between accreditation with commendation and accreditation with or without recommendations for improvement can be difficult to discern. In fact, little variation exists in accreditation levels and scores: 99 percent of the hospitals surveyed between May 1995 and June 1998 clustered in just 2 of the 5 possible accreditation levels.

UNANNOUNCED SURVEYS

The Joint Commission's reliance on unannounced surveys is limited.

The Joint Commission conducts 1-day, random unannounced surveys to ensure continued compliance with accreditation standards between triennial surveys. From June 1995 through May 1998, it conducted such surveys, providing 24 to 48 hours notice, on about 5 percent of its accredited hospitals.

RESPONSES TO MAJOR ADVERSE EVENTS

The Joint Commission treats major adverse events as opportunities for improvement. Accordingly, it emphasizes education, prevention, and confidentiality but limits public disclosure on the causes, consequences, and responses to such events.

The Joint Commission's sentinel event policy stresses self-reporting and analysis on the part of the hospitals. Through this approach, it aims to develop a database of events that it can analyze for frequency and causes. But ensuring confidentiality to self-reporting hospitals limits public accountability. This presents particular difficulties if, as it often the case, local concern is heightened because of media reports on the events.

RESPONSES TO COMPLAINTS

The Joint Commission devotes little emphasis to complaints.

The Joint Commission's accreditation process is not particularly geared to dealing with complaints. Although it receives complaints during surveys, surveyors must squeeze time from other survey activities to respond to them. The Joint Commission also receives and responds to complaints centrally.

STANDARDIZED PERFORMANCE DATA

Despite the Joint Commission's early plans, standardized hospital performance data remain of little value to external assessments of hospital quality.

In 1986, the Joint Commission unveiled its plans for a performance-based accreditation system that included uniform data from all hospitals. But as that vision unfolded, the Joint Commission faced resistance from hospitals. Accredited hospitals must now participate in a Joint Commission-approved measurement system (of which there are many), but collecting uniform data is as yet unrealized.

CONCLUSION

Unquestionably, the Joint Commission is the central force in the external review of hospital quality. It accredits about 80 percent of the hospitals in the country and, for Medicare purposes, it has a congressionally granted deeming status that is unique among accrediting bodies. Medicare beneficiaries and others who rely upon hospital services have much at stake in how and how well the Joint Commission does its job.

Our review underscores that the core element of the Joint Commission's approach to accreditation is the announced, on-site survey of hospitals--a survey that is heavily oriented toward educational and performance improvement objectives. The other elements of external review--unannounced surveys, responses to complaints and serious

incidents, and standardized performance measures--play relatively minor roles in the Joint Commission's accreditation process.

Given the significance of the Joint Commission's role and its emphasis on one approach to external quality review, our inquiry surfaces important policy questions for HCFA: How can it best ensure an appropriate balance in external quality reviews of hospitals? How can it best hold the Joint Commission accountable for the important public role it performs while enabling it, at the same time, to have enough flexibility to continue to advance the state-of-the-art of hospital accreditation? We address these questions in our summary report, *A Call for Greater Accountability*. That report also contains our recommendations, which we direct to HCFA.

COMMENTS

Within the Department of Health and Human Services, we received comments from HCFA. We also solicited and received comments from the following external parties: Joint Commission on Accreditation of Healthcare Organizations, Association of Health Facility Survey Agencies, American Osteopathic Association, American Association of Retired Persons, Service Employees International Union, National Health Law Program, and Public Citizen's Health Research Group. We include the detailed text of all of these comments and our responses to them in our summary report, *The External Review of Hospital Quality: A Call for Greater Accountability* (OEI-01-97-00050).

TABLE OF CONTENTS

	PAGE
EXECUTIVE SUMMARY	
INTRODUCTION	6
FRAMEWORK FOR EXTERNAL QUALITY REVIEW OF HOSPITALS	9
PROFILE OF ACCREDITATION	10
ANNOUNCED SURVEYS	
Approach: Collegial Tone and Tight Structure	11
Strengths: Dynamic Standards, Risk Reduction, Quality Improvement	13
Limitations: Unlikely to Uncover Substandard Care or Poor Performers	15
Scoring: Valued by Hospitals, But Scores Make Few Distinctions	18
UNANNOUNCED SURVEYS	
Limited Reliance	21
RESPONSE TO MAJOR ADVERSE EVENTS	
Opportunities for System Improvement	22
Lack of Public Disclosure	25
RESPONSE TO COMPLAINTS	
Little Emphasis	26
STANDARDIZED PERFORMANCE DATA	
Currently of Little Value to External Review	27
CONCLUSION	29
APPENDICES	
A: Medicare Conditions of Participation	30
B: Methodology	31
C: Sample Accreditation Survey Agenda	33
D: Advertising Accreditation Status	36
E: Endnotes	37

INTRODUCTION

PURPOSE

To assess the role of the Joint Commission in the external review of hospital quality.

BACKGROUND

Hospital Safety

Hospitals are an integral part of our healthcare system, offering services that improve, extend, and even save lives. But they are also places where inappropriate care can lead to unnecessary harm. This reality was clearly underscored in 1991, when a Harvard medical practice study revealed the results of its review of about 30,000 randomly selected records of patients hospitalized in New York State during 1984. The study found that 1 percent of the hospitalizations involved adverse events caused by negligence.¹ On the basis of its sample, the study team estimated that during that year, negligent care provided in New York State hospitals was responsible for 27,179 injuries, including 6,895 deaths and 877 instances of “permanent and total disability.” Many other more recent studies have reinforced the concerns raised by the Harvard study. Of particular note was one that focused on the care received by 1,047 hospitalized patients in a large teaching hospital affiliated with a medical school. It found that 17.7 percent of these patients received inappropriate care resulting in a serious adverse event—ranging from temporary disability to death.² In the public eye, these scholarly inquiries have been overshadowed by media reports that describe, often in graphic detail, the harm done to patients because of poor hospital care.³

Hospitals rely upon a variety of internal mechanisms, from physician credentialing, to peer review and benchmarking, in order to try to avoid such incidents and to improve the quality of care provided in their facilities. External quality review serves as a vital additional safeguard. It provides a more detached, independent mechanism for assessing the adequacy of hospital practices. Such oversight is of fundamental importance to patients and to the public and private entities that purchase health care services on their behalf. Protecting patient safety and improving the quality of patient care must be a top priority of external review.

Medicare’s Interest in External Hospital Quality Review

The Medicare program covers about 38 million elderly and disabled individuals, many of whom are high users of hospital care.⁴ In 1997, Medicare spent \$136 billion on Part A, the hospital insurance benefit. This figure is just over half the total amount the

Federal Government spent on all Medicare benefits.⁵ In the same year, Medicare spent over \$80 billion for inpatient acute hospital care alone.⁶

Since Medicare's inception, external quality review has been a part of the Medicare program. When Congress enacted the Medicare Act in 1965, it required hospitals to meet certain minimum health and safety requirements to participate in the program.⁷ Those minimum requirements, called the Medicare conditions of participation, were published in 1966, revised in 1986, and are now being revised again (see appendix A).⁸ Within the Medicare Act itself, however, Congress provided that hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations were deemed to be in compliance with the conditions of participation. Congress also provided that hospitals accredited by the American Osteopathic Association could be considered in compliance, but only to the extent that the Secretary deemed appropriate.⁹ Thus, accreditation by the Joint Commission or the American Osteopathic Association provides entree into the Medicare program. About 80 percent of the 6,200 hospitals that participate in Medicare are accredited by the Joint Commission. Those hospitals wishing to participate in Medicare without accreditation must go through a Medicare certification process. The Health Care Financing Administration (HCFA) relies on State survey and certification agencies (hereafter called State agencies) to conduct certification surveys at these hospitals to determine compliance with the Medicare conditions. States currently certify 1,442 nonaccredited hospitals nationwide.¹⁰

Regardless of the route a hospital takes to Medicare participation, Medicare bears a cost for the external review, either directly by funding State surveys or indirectly through hospital charges that include the overhead cost of periodic accreditation surveys.

The Nature of Accreditation

Accreditation is a form of self-regulation. It is a voluntary “conformity-assessment process” whereby industry experts define what standards organizations must meet in order to be accredited and then systematically review the organization's performance against those standards.¹¹ It typically aims to improve performance.¹² Organizations wishing to be accredited pay a fee for that service.¹³

This Inquiry and Report

This report examines the role of accreditation in external hospital quality review. It focuses on the Joint Commission on the Accreditation of Healthcare Organizations because it dominates the hospital accreditation market.¹⁴ In this report, we offer a framework for considering the external review of hospital quality and apply that framework to the Joint Commission's approach to hospital accreditation.

This report is part of a series of four companion reports that resulted from our inquiry. A second, *The Role of Medicare Certification* (OEI-01-97-00052), describes the extent and nature of the external review for nonaccredited hospitals. A third, *Holding the Reviewers Accountable* (OEI-01-97-00053), describes how HCFA oversees both the Joint Commission and the State agencies. The fourth report, *A Call for Greater Accountability* (OEI-01-97-00050), provides a summary of external hospital quality review and presents the recommendations emerging from our inquiry.

Our inquiry draws on a variety of sources. These include: data from HCFA's Online Survey Certification and Reporting System; aggregate data from the Joint Commission concerning hospital survey activity; a mail survey to State agencies in the 50 States and District of Columbia (hereafter referred to as a State); observations of seven routine hospital surveys conducted by the Joint Commission and one conducted by a State agency; observations of two separate complaint surveys conducted by a State Agency; reviews of accreditation manuals, policies, and hospital survey files from the Joint Commission; the systematic gathering of information from representatives of HCFA central and regional offices, State agencies, the Joint Commission, American Hospital Association, consumer groups, professional associations, and representatives of other organizations we considered to be stakeholders in hospital oversight; and reviews of laws, regulations, and articles from newspapers, journals, newsletters, and magazines. We also interviewed officials from the American Osteopathic Association and reviewed their accreditation materials. The American Osteopathic Association accredits about 100 to 150 hospitals, some of which are also accredited by the Joint Commission. For purposes of this inquiry, however, we focused on the Joint Commission. See appendix A for more details on our methodology.

We conducted this inspection in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

HOSPITAL REVIEW FRAMEWORK

The following five components present a framework for considering the external quality review of hospitals. They are intended to complement the internal quality assurance and improvement efforts that hospitals undertake themselves. They are approaches that health care purchasers, such as Medicare and Medicaid, can rely upon to ensure that their beneficiaries receive quality services from hospitals. They can also be of use to beneficiaries and other consumers concerned about the quality of their hospital care.

We present the components to facilitate analysis of the extent and type of external review that is desirable, whether carried out by accreditation bodies, certification agencies, Medicare Peer Review Organizations, HCFA, or others. Each component has strengths and limitations. Moreover, each can be used in support of a review philosophy based on continuous quality improvement, more traditional compliance enforcement, or some combination thereof.

We omitted a sixth component: the retrospective review of medical records to determine appropriateness of care. Formerly a role of the Medicare Peer Review Organizations, such medical record review is no longer carried out on such a large scale. However, some medical record review does occur as part of the components described below.

1. Announced, On-Site Surveys of Hospitals

These involve some combination of observations of facility and equipment; reviews of medical credentials, and other records and documents; and interviews. They result in a pass/fail or some kind of score intended to distinguish level of performance. They can also involve follow-up to correct or improve.

2. Unannounced, On-Site Surveys of Hospitals

The approach is basically the same as above except that the hospital has not had time to prepare. The intent is to gain a clear assessment of the facility as it typically functions and to trigger any necessary follow-up.

3. Response to Complaints Concerning Hospitals

These involve complaints of a particular instance of care or more encompassing matters concerning a hospital's performance. The response to complaints can range from a minimal distant review to a thorough on-site review. The process can trigger corrective actions and system improvements.

4. Response to Major Adverse Events in Hospitals

These involve cases where substantial patient harm resulted from what may be poor performance on the part of the hospital and/or its practitioners. Here, too, the response can range from minimal to thorough and can trigger corrective actions and system improvements.

5. Collection and Dissemination of Standardized Performance Measures

The aim here is to establish the standardized use of measures in ways that enable purchasers, consumers, accrediting bodies, and others to compare hospital performance. The comparisons can focus on a hospital's own performance over time and/or on how its performance compares to other hospitals. The data can be drawn from surveys of patients or providers, billing claims, and the hospitals' own records.

PROFILE OF ACCREDITATION

The table below summarizes our assessment of the Joint Commission's approach to hospital accreditation, based on the framework we presented on the previous page. The remainder of the report follows this framework and elaborates on the five elements of the summary.

Element	Description	Degree of Emphasis
Routine, Announced, On-Site Surveys	Conducted every 3 years to measure compliance with over 500 standards in 45 performance areas.	Major. Core of existing accreditation process
Random, Unannounced, On-Site Surveys	Conducted on a sample of hospitals as a measure of continued compliance with standards in five performance areas.	Minor. Affects about 5 percent of accredited hospitals per year.
Responses to Complaints	Includes tracking for trends but also some follow-up on-site, depending on the nature of the complaint.	Minor. Few complaints result in on-site surveys; most are reviewed for trends. Limited attention to complaints during triennial surveys.
Responses to Major Adverse Events	Policy calls for hospital self-reporting and determining cause of event. Focus is on identifying opportunities for improvement and education.	Minor to Moderate. Emphasis has been growing.
Standardized Performance Data	Hospitals participate in one of many Joint Commission-approved indicator system and begin submitting data in 1999.	None. Performance data not linked to accreditation.

ANNOUNCED SURVEYS

APPROACH

Joint Commission surveys are undertaken in a collegial manner.

Joint Commission surveyors are experienced nurses, physicians, and administrators. They are keenly aware of their roles as outside reviewers responsible for documenting compliance with Joint Commission standards. But they seek to carry out that role more as peer reviewers than as enforcers or regulators. In interacting with hospital staff, they strive to foster a collegial atmosphere characterized by a joint interest in improving hospital performance.

It follows, therefore, that surveyors view education as a central part of their mission. Well-versed in the Joint Commission standards, they tend to be ambassadors of those standards, helping hospital staff to understand their intent and significance. Beyond that, they also use the survey as a way of informing hospitals about promising approaches they have found at other hospitals, even providing the names of individuals to contact. For example, we observed surveyors informing hospital staff of alternate methods for monitoring crash carts and sharing other hospitals' approaches to defining privilege lists and adverse drug reactions. We also observed a surveyor briefly chat with a patient and then scan his chart to identify how the hospital staff recorded the goals set for this patient. While the surveyor identified dietary, rehabilitation, and medical goals in the chart, the chart lacked documentation reflecting the patient's own stated goal: to ride his motorcycle again. This led to some educational discussion between the surveyor and caregivers on reflecting goals not only for individual disciplines, but also in terms of the patients and their needs as individuals.

Given their collegial and educational orientation, surveyors tend to approach their information gathering in a nonchallenging manner. For example, they allow the hospital to select the majority of records to be reviewed.¹⁵ They tend to be accepting of information and answers provided by the hospital staff, with little probing to determine if surface appearances describe actual practice. They seldom reflect any wariness that hospital staff, in their eagerness to impress surveyors, may exaggerate points or omit information. For example, in one hospital, a surveyor scanned some performance data prominently displayed on a storyboard, questioned the cause of significant deviation in the charted data, but when staff failed to respond did not pursue the matter. In another, a surveyor noted with surprise that the hospital staff had failed to pull certain files he requested, but did not insist that the requested files be provided.

Joint Commission surveys are tightly structured.

The Joint Commission uses a standard agenda in surveying hospitals. In 2 to 5 days, depending on hospital size, surveyors conduct dozens of individually scheduled sessions that cover the major aspects of a hospital's operations (see appendix B for a sample agenda). The survey pace is rapid, typically allowing 45 to 60 minutes for each meeting or patient care visit before moving on to the next visit.¹⁶ A few 15-minute intervals might be allotted each day as unscheduled for surveyors' personal time or phone calls. Sessions are scheduled back to back.

The survey provides surveyors with a general overview of the hospital. It facilitates standardized assessments across facilities and protects against inconsistencies or the special interests of individual surveyors. Also, because the schedule, which hospitals receive in advance, spells out exactly which surveyor will be where over the course of the survey, individual departments can prepare by having everyone ready for the surveyor and the area cleaned and organized.¹⁷

The packed agenda, however, affords few opportunities for surveyors to develop hunches, follow leads, or even respond to complaints. Racing from session to session, surveyors have little time to probe deeply. As one surveyor described after surveying a 700-bed hospital, "The team found this to be a harried, rushed survey due to the number of areas covered and the timeframe allowed...Patient units were cut short to allow for travel time between buildings...The time allotted for the building tour and medical record review was grossly inadequate."¹⁸

The surveyors know little going in to a hospital that might help them probe more effectively. Their advance knowledge is limited to some basics on the services offered, last triennial survey results, and, in some cases, complaints and media articles. They know little, if anything, about the local health care market in which the hospital operates, including whether there are local labor shortages or union disputes. While such limited knowledge deliberately reduces bias and promotes consistency, it also hinders targeted probing and a deeper understanding of the hospital's operations. For example, on the first day of a hospital survey, the local newspaper published a lead editorial about a heated battle between this hospital and another for dominance in children's services. This competition was much on the minds of the hospital's leadership, but the surveyors failed to ask about it because they were unaware of it. The surveyors were also unaware that the hospital had a random unannounced survey 18 months earlier.

STRENGTHS

Joint Commission standards are dynamic.

The Joint Commission's ability to quickly adapt the standards that form the foundation of the accreditation process enables it to respond to changes in health care delivery and evaluation methodology. The Joint Commission is constantly developing new, refining existing, and eliminating out-of-date standards. Practitioners, experts, and stakeholders from around the country weigh in on this process through the Joint Commission's committee structure. That committee includes representatives from professional and industry groups, such as the American Medical Association, the National Association of Healthcare Quality, and the American Academy of Family Physicians, as well as from the Health Care Financing Administration. The stakeholders we surveyed considered ability to improve standards without a long regulatory process to be one of the greatest strengths of the accreditation process. Even a critic of the Joint Commission conceded that "the standards are wonderful. [One] can't help but admire them."

Over the past decade, the Joint Commission's standards changed dramatically.¹⁹ The new and revised standards reflect a more patient-centered focus, with greater emphasis on patient rights. The Joint Commission replaced old standards concerning committee meeting minutes with standards on strategic planning, resources for continuous quality improvement, and managing information. These changes were so substantial that, by 1996, the Joint Commission eliminated 80 percent of standards from its 1986 manual.²⁰

Joint Commission surveys serve as a means of reducing risk.

At its core, the survey process is about reducing risk. The surveys prompt hospitals' attention to minimum protections that are important to patients.²¹ Hospitals know that once every 3 years the surveyors will be onsite and they take the accreditation process seriously.²² They know the survey dates in advance and prepare for them. The survey process gives the hospital's leadership a platform from which to rally attention to assessing its condition and correcting problems in time for the survey; hospitals want to put their best foot forward. For example, prior to surveys, hospitals put extra efforts in their appearance and make sure manuals are up-to-date. Many hospitals hire consultants to help them with this process by conducting mock surveys or reviewing existing conditions to identify areas falling short of accreditation standards. While some of these efforts are cosmetic, others extend beyond the cosmetic and include efforts such as training staff on standards.

Of course, the Joint Commission also has a platform from which it can promote particular patient-centered concerns by simply making them survey priorities. For example, over the past several years, the Joint Commission has identified hospital use of patient restraints as a such a priority.²³ Indeed, surveyors found problems with restraints

at 55 percent of hospitals surveyed between June 1995 and May 1997.²⁴ Hospitals were well aware of this focus--newsletters and Internet chat rooms devoted to accreditation surveys often feature survey trends--and responded through efforts such as improvement projects aimed at reducing restraint use.²⁵ Other topics garnering attention from the Joint Commission recently include smoking in hospitals, conscious sedation, and emergency medicines.

In addition to focusing on priority areas such as restraints, the triennial surveys reinforce attention to other, basic protections that span administrative and clinical realms. For example, surveyors review hospitals for their fire safety procedures, including reviewing fire drill logs and checking fire doors and firewalls. They check the security and expiration of medicines and supplies. They look for infection control issues such as separation of clean and dirty. They check how hospitals record drug allergies and monitor adverse drug reactions. They review the timely inclusion of histories and physicals in the medical records. They verify the existence and staff knowledge of hospital policies. For example, at one hospital, we observed the nurse surveyor review policies and minutes of the ethics committee. He then verified that nurses on patient care units used the committee appropriately by asking about their most recent referrals to it.

Joint Commission surveys foster attention to continuous quality improvement.

Consistent with its mission to “improve the quality of care provided to the public through...performance improvement in health care organizations,” the Joint Commission promotes the use of continuous quality improvement through the measurement of performance based-standards.²⁶ Continuous quality improvement has been a major trend in health care over the past decade, and the Joint Commission adopted its focus on measurement and outcomes through its Agenda for Change.²⁷ In fact, 88 percent of the stakeholders we interviewed expect accreditation to play a great or very great role in fostering continuous quality improvement in hospitals.

Attention to continuous quality improvement pervades the entire hospital survey process. The performance improvement overview session, one of the first sessions of the survey, provides an opportunity for hospital staff to present their performance improvement methodology, to which surveyors refer throughout the survey.

Fostering An Understanding of Measurement

While surveying a unit serving the frail elderly, a nurse surveyor engaged staff in a discussion about identifying and measuring patient outcomes. Through careful questioning, he led the staff to understand the difference between the process of care (in this case, a moist healing environment for a pressure ulcer) and the outcome of care (a smaller and, eventually, healed ulcer). He also helped the staff understand the importance of measuring the impact of the staff's interventions on patient outcomes.

Surveyors reinforce the importance of quality improvement in sessions with hospital leaders and medical staff, where they confirm leadership involvement and ask how projects are identified and prioritized. The survey agenda also reserves specific sessions for performance improvement teams to showcase their most successful projects for surveyors. The performance improvement projects presented may involve topics such as reducing patient waiting times, improving the timeliness of medical record retrieval, reducing medication errors, and reducing the use of patient restraints. As the surveyors move throughout the hospital, staff are eager to explain the performance improvement storyboards on display in their units. And surveyors often ask staff what their units are doing better this year than last and what they will do better next year.

Depending on the hospitals' sophistication in performance improvement, surveyors act as either educators, sharing advice and encouragement on measuring outcomes, or as cheerleaders, applauding the hospitals' performance improvement efforts. Some hospitals have moved beyond Joint Commission requirements, hiring consultants to help them with their performance improvement efforts, sending medical staff to training on these techniques, or paying medical staff for time spent on performance improvement projects. In hospitals with sophisticated performance improvement projects, surveyors offer compliments and collect ideas to pass on to other hospitals.

LIMITATIONS

Joint Commission surveys are unlikely to surface patterns, systems, or incidents of substandard care.

Looking for questionable care runs counter to the tight structure and collegial nature of the Joint Commission's survey process. That process leaves little opportunity for identifying such patterns, systems, or incidents. It is more oriented toward reducing risks, improving performance, and educating.

The Joint Commission's approach to medical record review illustrates its limits. While surveyors review both closed and open medical records during surveys, their focus is more on processes of care than appropriateness of care. In fact, surveyors "do not judge directly whether the care given to a specific patient is good or bad, right or wrong."²⁸ Nor do they choose medical records based on indications of poor quality. Rather, the hospitals generally choose the records for surveyors, and, in some cases, hospital staff also conduct the review. While Joint Commission surveyors find problems--even patterns--through medical record review, they tend to be related to processes, such as documenting verbal orders, timely recording of the history and physical, and assessing patients' educational needs. While important, these process issues are apparent through even a quick review of the records. The Joint Commission's approach is unlikely to reveal problems or patterns that might take a more thorough examination to uncover, such as inappropriate surgeries, high complication rates, or poor or unexpected outcomes.

The Joint Commission survey process falls short of identifying patterns or systemic weaknesses because, at least in part, surveyors lack the time or the up-front knowledge that would help them dig deeper. They get a broad rather than in-depth view of the hospitals' operations. Thus, the survey would be more apt to reveal unsecured narcotics or outdated drugs than it would a pattern of mismeasurement. It would be more apt to reveal lapses in fire drills than lapses in continuity of care. It would be more apt to reveal overdue staff evaluations than staff performing tasks for which they are untrained.

Indeed, the survey process may not reveal any problems when in fact systemic problems exist. For example, in the Spring of 1996, the Joint Commission awarded one hospital its highest level of accreditation: accreditation with commendation. That Fall, the hospital experienced an unexpected death, triggering the State agency to investigate. In the spring of 1997, more unexpected deaths occurred, and the agency returned. After a 3-week investigation, that agency found systemic problems in both quality assurance and medical staffing.²⁹ While no system of oversight is foolproof, the Joint Commission survey process failed to uncover what the State agency identified as deep-rooted problems.

Joint Commission surveyors have limited information from which to draw to help them identify patterns or incidents. For example, surveyor preparation packets lack practice pattern or performance data that could provide surveyors with insights into identifying patterns of questionable care. In fact, the surveyors have virtually no interactions or information from other stakeholders, such as Medicare Peer Review Organizations or consumer groups, who might have insights into the hospitals' performance.

Joint Commission surveys are unlikely to identify individual practitioners whose judgment or skills to practice medicine are questionable.

The collegial process, tight structure, limited time, approach to medical records, and lack of background information all make it unlikely that the survey process will identify individual practitioners who pose risks to their patients. In fact, the Joint Commission's own publications note that the accreditation process does "not evaluate the quality of care provided by individual medical staff members" and "does not provide a warranty that a particular individual will receive quality care in a specific health care setting at a particular time."³⁰

A standard part of an accreditation survey is a review of hospitals' own processes in ensuring the competence of their practitioners. But that review of credentialing and privileging offers, at best, a preliminary and superficial assessment. It generally lasts 45 to 60 minutes, during which the surveyor both interviews the medical staff leadership and reviews files (in some cases, the hospital staff also reviews files).

While the hospitals generally choose the files for review in the credentials session, they do so at the direction of the surveyors, ensuring different privileges (active, courtesy, consulting, and temporary, for example) and specialties are represented. But time is too short for any in-depth review of these files. For example, in one hospital with over 500 active staff, the surveyor reviewed three practitioners' credentials and privileges. Even though he found a problem with one of the three (a podiatrist who was performing surgery for which he was not privileged), the surveyor reviewed no additional files.

The credentials session falls short in other ways, as well. While the surveyors do ask important questions about the hospitals' processes for matching privileges to competencies and verifying licenses, we observed no surveyor ask how the hospital identified or dealt with physicians whose knowledge or practice skills were marginal.³¹ Even though Federal law requires hospitals to report any practitioner they have disciplined to the National Practitioner Data Bank, it is unlikely that surveyors will make any determination about hospitals' compliance with that law: Joint Commission standards do not currently reference the law for reporting to the Data Bank, and the likelihood is low that surveyors will choose a file of a disciplined physician randomly.³² In fact, one physician surveyor chastised the staff for pulling confidential physician files for the surveyor to review. Such files contain peer review assessments and other details on the physicians' skills.

The collegiality of the sessions hinders raising sensitive topics, such as physicians' fitness to practice, in a meaningful way. For example, during the review of credentials, one physician surveyor shared a story about a hospital that was about to reduce privileges of an older surgeon whose skills had declined. The surgeon had practiced at the hospital for many years and was a stalwart of the hospital community and respected throughout the State. Before the hospital could act, the State legislature named the surgeon "Physician of the Year." The story was met with nervous laughter by the medical staff. While the story touches on the difficulties of dealing with those whose skills are declining, the surveyor followed up with neither questions of whether the hospital was faced with anything similar nor education about how to deal with such situations.

Other survey sessions offer some insights into the practitioners skills, but only peripherally. For example, the document review session provides an opportunity for surveyors to review any minutes or records that might document some problems with individuals, though whether the surveyors would have the time to identify those documents amidst the hundreds they scan is uncertain at best. The surveys also include interview sessions with nursing and medical leadership. But the high attendance and collegial atmosphere at these sessions is generally counter to discussing individuals.

SCORING

Joint Commission survey results matter enormously to hospitals.

Hospitals attach great significance to accreditation scores and status. They know the accreditation scores of competing hospitals, and aim to beat them with higher scores of their own. It is not enough to simply be accredited--nearly every hospital surveyed gets accredited--they want to be accredited with commendation, the highest level awarded by the Joint Commission. After all, hospitals operate in an increasingly competitive marketplace, where edging out the competition in gaining contracts with managed care plans and other purchasers can be the difference between surviving and going out of business. They know that their survey results will be available to the public.³³ Thus, hospitals that do achieve accreditation with commendation promote their survey results (see appendix D).³⁴ They advertise their status in banners hung outside their hospitals. They announce it in full-page ads in their local papers. They post it on their websites and throughout the hospital.

This focus on the survey scores permeates the survey process, introducing some tension into the otherwise collegial process. Surveyors know hospitals aim to do well on their surveys--after all, the hospital leadership often follows them around during the entire survey process. Hospitals often hire consultants to help them prepare and increase the likelihood they will achieve accreditation with commendation. Surveyors and hospitals alike know that just one deficiency can thwart accreditation with commendation. This can lead to pressure to mitigate the impact of deficiencies, which can play out in a couple of ways. One approach, for example, involves what we have dubbed the denominator game: increasing the numbers of documents reviewed (the denominator) in order to decrease the significance of problems identified in any one record (the numerator).³⁵ We observed hospitals attempting to mitigate findings on restraints, dental histories in the medical record, and security of drugs with this approach, with varied success. Surveyors, of course, also have some flexibility in scoring the standards. For example, we observed one surveyor identify a problem with a podiatrist performing surgery that exceeded his privileges. The surveyor scored this as a documentation rather than medical staff problem, thereby mitigating its impact on the final score.

Joint Commission survey results fail to make meaningful distinctions among hospitals.

Even though the Joint Commission has 5 levels of accreditation, 99 percent of the hospitals surveyed between May 1995 and June 1998 clustered in just 2 of those levels (see table 1): accreditation with commendation (16 percent) and accreditation with type 1 recommendations (83 percent).³⁶ The difference between some levels of accreditation can be difficult to discern. For example, hospitals accredited without recommendations for improvement may miss the commendation status by a narrow margin. On the other hand, accreditation with recommendations for improvement (type 1 recommendations) is a broad category that encompasses hospitals with just one recommendation to hospitals having many.³⁷

Table 1
Accreditation Levels for Hospitals Surveyed
June 1995 - May 1998

Accreditation Level	6/95 to 5/96	6/96 to 5/97	6/97 to 5/98	Total
Accreditation with Commendation	13%	18%	15%	16%
Accreditation without Type 1 Recommendations	<1%	1%	0	<1%
Accreditation with Type 1 Recommendations	86%	80%	83%	83%
Conditional Accreditation	<1%	1%	1%	1%
Preliminary Non-Accreditation	0	0	<1%	<1%

Source: Joint Commission on the Accreditation of Healthcare Organizations.

Note: n=17130 for 6/95-5/96, n=1709 for 6/96-5/97, and n=1719 for 6/97-5/98.

In addition to the accreditation level, hospitals accredited by the Joint Commission receive a score based on a 100-point scale. Fully 99 percent of hospitals accredited in 1997 received scores over 80: 73 percent received scores of 90 or higher and 26 percent, from 80 to 89. Just 1 percent received from 70 to 79.³⁸ Given the Joint Commission’s own interpretation of scores, this spread implies few “real differences” across accredited hospitals:

The smaller the difference in scores between hospitals, the less likely there is an actual difference in the levels of performance between them. There may not be a real difference between a hospital that scores 88 and a hospital that scores 81. However, the greater the difference in scores, the more likely there is a difference in patient care.³⁹

On at least one occasion, the Joint Commission has found its own survey too blunt a tool to clearly distinguish a hospital as unacceptable. In this case, two State agencies, HCFA, and the Joint Commission were engaged in surveying and resurveying a hospital. Concerns about this hospital ranged, for example, from rat infestations to the hospital taking away a patient’s mattress and bedframe, to improper patient restraints. Yet it was

not until the Joint Commission devised a special survey that the hospital failed to achieve accreditation.

UNANNOUNCED SURVEYS

The Joint Commission's reliance on unannounced surveys is limited.

The Joint Commission uses random unannounced surveys as a way to ensure continued compliance with accreditation standards between triennial surveys.⁴⁰ From June 1995 through May 1998, the Joint Commission conducted 250 random unannounced surveys, representing about 5 percent of its accredited hospitals. Eleven percent of those surveys (28) resulted in a change in the hospitals' accreditation status. The Joint Commission required some corrective follow-up (a written progress report or a focused survey) for about a third (80, or 32 percent).

The Joint Commission does, in fact, give advance notice of its "unannounced" surveys. But unlike the triennial surveys, which are scheduled several months in advance, the Joint Commission provides considerably less notice to hospitals undergoing these random surveys: generally 24 to 48 hours. By contrast, the New York State Health Department recently sent 72 inspectors to 12 hospitals without any warning at all. The inspectors arrived at the hospitals on a Thursday afternoon and spent the weekend investigating the hospitals' supervision of residents.⁴¹ State agencies, in conjunction with the Health Care Financing Administration, often give no warning to hospitals prior to showing up to investigate a complaint or incident of patient harm.⁴² In fact, in the case of nursing homes, Federal law allows a fine of up to \$2,000 for anyone warning the facility of an upcoming survey.⁴³ Some hospitals appear to recognize some intrinsic value to the surprise of an unannounced evaluation, as they themselves hire people to pose as patients and then report on their experience.⁴⁴ The Joint Commission has not used that approach.

The focus of random unannounced surveys is narrower than the triennial surveys. Rather than encompassing all hospital accreditation standards, they focus on the top five performance areas that the Joint Commission finds out of compliance. Because of the narrower focus, one surveyor conducts the random unannounced and the entire survey takes 1 day. The one random unannounced survey we observed began at 8:30 in the morning and ended at 3:15 in the afternoon. The Joint Commission notified that hospital 24 hours before the surveyor, an administrator, arrived at the hospital. The survey resembled the triennial survey in approach. For example, the surveyor conducted the survey in the same collegial manner as in a triennial; he often focused on educating the hospital staff on particular standards and their intent. His advance knowledge of the hospital was limited to a copy of the notice to the hospital's executive explaining the focus of the survey and a sheet describing some basic information about the hospital and its services. He displayed little skepticism. In fact, during one 5-minute interview of the human resources staff, the surveyor proclaimed their answers to be "textbook perfect," thereby negating his need to review any of the files they had pulled for him.

Responses to Major Adverse Events

The Joint Commission’s approach to major adverse events has evolved to one that addresses such events as opportunities for system improvement. It is in accord with recently developed precepts on reducing errors in medicine.

In recent years, as the media have reported many events involving serious harm to hospitalized patients, the Joint Commission has devoted more attention to them under the rubric of its “sentinel event” policy.⁴⁵ When it first established this policy in April 1996, it assessed the hospital’s responsibility for them through an on-site investigation.⁴⁶ If the Joint Commission found that the incident was, indeed, serious, and that the hospital could reasonably have been expected to prevent it, then the Joint Commission typically downgraded the hospital’s accreditation to “conditional”--a publicly disclosed status that called for the hospital to determine the cause of the event.⁴⁷

Since then, the Joint Commission’s sentinel event policy has evolved to one that is gentler to hospitals. Its first important move in this direction was in October 1996 when it replaced the downgrade to conditional accreditation, which hospitals regarded as unnecessarily punitive, with a status called “Accreditation Watch”-- a publicly discloseable status but one that in itself did not affect a hospital’s existing accreditation status. More significantly, in April 1998, the Joint Commission recast its overall approach toward such events to one that is much more analytic than investigative. This altered approach builds on the premise that medical errors occur regularly, even in the best hospitals. It seeks continuous quality improvement in health care by treating errors as opportunities to improve systems of care rather than to find and punish culpable individuals or institutions. Toward this end, it aims to create a protected venue where it is safe to acknowledge errors and where practitioners and administrators analyze them to develop better error-prevention strategies--ones that get at the causes for errors.⁴⁸

The Joint Commission’s Definition of a Sentinel Event

“(1) The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition, or (2) The event is one of the following (even if the outcome was not death or major permanent loss of function): Suicide of a patient in a setting where the patient receives around-the-clock care (e.g., hospital residential treatment center, crisis stabilization center); Infant abduction or discharge to the wrong family; rape; Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities; or Surgery on the wrong patient or wrong body part.”

Thus, the Joint Commission's current policy on major adverse events stresses voluntary and timely self-reporting both of the incidents and of the hospitals' analyses of them.⁴⁹ Hospitals that proceed in this way avoid Accreditation Watch and are much less likely to be subject to an on-site investigation of an incident. Through this approach, the Joint Commission expects to develop a substantial database of events that it can analyze for patterns of frequency and causes.⁵⁰ It intends to communicate this information to accredited hospitals so that they can prevent such events.

It is still early to fully assess the effects of this new approach. But the initial indications suggest that this gentler, educationally oriented approach is beginning to take hold. From April 1, 1998 (when the policy was implemented) until January 7, 1999 (the latest date for which data are available), the Joint Commission has been less inclined to place hospitals on Accreditation Watch or to change their accreditation status as a result of an adverse event, and hospitals have been more inclined to self-report sentinel events to the Commission (see table 2).⁵¹

Table 2
Sentinel Event Tally

Sentinel Events in the Database	
Total Number of Events Added to the Joint Commission Database between 4/1/96 and 1/7/99	374
Number Self-reported 4/1/96 - 3/31/98	36
Number Self-reported since the New Policy (4/1/98 and 1/7/99)	115
<hr/>	
Hospitals on Accreditation Watch	
Total Number of Hospitals Placed on Accreditation Watch 10/1/96 - 1/7/99	38
Number 10/1/96 - 3/31/98	35
Number since the New Policy (4/1/98 and 1/7/99)	3
<hr/>	
Hospitals with an Accreditation Status Change	
Total Number of Hospitals with a Change in Accreditation Status Due to Sentinel Event Review between 10/1/96 and 1/7/99	149
Number 10/1/96 - 3/31/98	146
Number since the New Policy (4/1/98 and 1/7/99)	3

Source: Joint Commission on the Accreditation of Healthcare Organizations.

The Joint Commission’s approach emphasizes confidentiality, thereby inhibiting public disclosure on the causes, consequences, and responses to major adverse events.

For hospitals complying with the Joint Commission’s self-reporting format, the Joint Commission does not publicly release any information, nor upon inquiry of a hospital’s accreditation status does it identify that any analysis is underway. If the inquirer specifically mentions the adverse event, the Joint Commission simply indicates that it is working with the hospital on it. But even with this restrictive approach, hospitals have been wary of the self-reporting policy as they fear that the confidentiality of the Joint Commission’s database would not be adequately protected under State and Federal laws and that as a result they would be exposed to malpractice liability.⁵² The Joint Commission has been examining legislative remedies, at State and Federal levels, to address this concern and to buttress its limited disclosure policy.

This emphasis on the confidentiality of adverse event related information may facilitate the quality improvement agenda of the Joint Commission, but it is at the expense of its public accountability. It leaves the general public with minimal information about how an incident happened and what if anything is being done to prevent more. This presents particular difficulties if media reports of the incident heighten local concern. In such cases, the public is likely to be looking for assurances from an objective outside party that any problems at the hospital have been addressed and that patient safety is maintained. Under its current policy, the Joint Commission can offer few specifics to support any such assurances.⁵³ The results of investigations conducted by State agencies or HCFA itself are likely to be more available to the public.

RESPONSES TO COMPLAINTS

The Joint Commission devotes little emphasis to complaints.

The Joint Commission's accreditation process addresses complaints more tangentially than centrally. Although it receives and responds to complaints during triennial surveys, the limited time surveyors devote to complaints is squeezed from other survey activities in an already-packed agenda. And while the Joint Commission requires hospitals to inform the public about upcoming surveys 30 days in advance with notices that explain how to register complaints, it has no standing requirement for hospitals to post such notices continuously.⁵⁴

The rate of complaints the Joint Commission received through its triennial survey process (referred to as public information interviews) remained flat from 1996 to 1997: surveyors conducted 111 such interviews in 1996 and 103 in 1997, involving about 6 percent of surveys in each year.⁵⁵ Thirteen percent of the public information interviews resulted in areas identified for improvement (i.e., type 1 recommendations). Historically, such public information interviews took place with both surveyors and hospital representatives present, which likely had a chilling effect on staff wishing to complain. But in 1997, the Joint Commission changed its policy to allow confidential opportunities for public information interviews. It remains to be seen how this revised policy will affect the complaints received over time.⁵⁶

The Joint Commission also receives complaints in its central office, which it tracks for trends or sends to surveyors for review during triennial surveys.⁵⁷ In March of 1999, it implemented a new toll-free complaint hotline.⁵⁸ When a complaint or incident such as an unexpected death alerts the Joint Commission of a possibly grave threat to patient care or safety in an accredited hospital, it conducts either an unannounced or unscheduled survey (these differ from the *random* unannounced surveys discussed previously). During the 3-year period from June 1995 through May 1998, the Joint Commission conducted these surveys in about 6 percent of accredited hospitals (172 unannounced and 136 unscheduled surveys). While hospitals do not receive prior notice of an unscheduled survey, the Joint Commission gives 24 to 48 hours notice before an unannounced survey. Both types can result in changes in accreditation status and areas requiring follow-up.⁵⁹

Sometimes, the Joint Commission, HCFA, and/or the States agencies receive the same complaints. While some sharing of complaint information occurs, officials from State agencies, HCFA, and the Joint Commission all expressed some concern about the consistency of that sharing. Some also expressed concerns about the lack of coordination in following up on complaints.

Standardized Performance Data

Despite the Joint Commission’s early plans to incorporate standardized hospital performance data into accreditation, it remains of little value to external assessments of hospital quality.

In 1986, the Joint Commission unveiled its “Agenda for Change,” a vision for a performance-based accreditation system that included clinical indicators. It envisioned a system where data based on such indicators would enhance the accreditation process by making it more data-driven and providing insights into hospitals’ performance on a continuous basis.⁶⁰ That vision evolved to include public access to hospital performance reports and links between accreditation and performance measurement. While it has made strides in the former, linking accreditation to performance measurement has been more troublesome.

As its vision unfolded, the Joint Commission faced considerable hurdles. For some stakeholders, the Joint Commission was moving too fast on performance measures; for others, too slow. For example, its initial vision required hospitals to participate voluntarily in its own data system, called the Indicator Measurement System (IMS), until 1996, when participation would become mandatory. The hospital industry resisted the IMS, finding it expensive and burdensome.⁶¹ Concerns about the science of performance measurement and risk adjustment, considered by many to be still in its infancy, also plagued the Joint Commission’s implementation. Many hospitals had already invested in other competing performance measurement systems. The Joint Commission’s commitment to making hospital performance data public also rankled.

Thus, while the Joint Commission has maintained its vision of a performance-based accreditation system, it has proceeded at a much slower pace and with more flexibility than it initially sought. For example, it no longer requires hospitals to participate in the IMS. Instead, the Joint Commission offers two programs: Oryx and Oryx+. Oryx reflects the minimum requirement for accredited hospitals, which are required to choose a performance measurement system from a list of approved systems, of which IMS is one option.⁶² Hospitals wishing to do more than the minimum participate in Oryx+, which is an accelerated version of Oryx that requires participating hospitals to use the same 10 performance measures. Oryx supports comparisons only to individual hospitals’ own performance over time, whereas Oryx+ allows comparisons across participating hospitals.

With the exception of the hospitals participating in Oryx+, this approach left the Joint Commission a long way from its earlier vision of uniform data from all hospitals. In the words of one stakeholder, Oryx is akin to saying “you have to wear a school uniform

but may choose it yourself.” To advance its vision toward uniform data, the Joint Commission began collecting and evaluating potential “core performance measures” in late 1998.⁶³ Considered the next phase of the Oryx initiative, the Joint Commission aims to choose five or six areas (such as diabetes or breast cancer) to focus on by the end of 1999.

How this new phase of the Oryx initiative will unfold is unknown, but it has already caused considerable backlash. Seventeen State hospital associations wrote to the Joint Commission in January 1999 to voice their concerns about the core performance measures.⁶⁴ They raised many of the same concerns raised in 1995 when the Joint Commission introduced the IMS, including the costs, burdens to hospitals, and timing of implementation.⁶⁵

In addition to its Oryx initiatives, the Joint Commission recently joined forces with the American Medical Association and the National Committee for Quality Assurance to create the Performance Measurement Coordinating Council. The Council aims to develop standards for performance measurement with an eye toward more consistency.⁶⁶

CONCLUSION

Unquestionably, the Joint Commission is the central force in the external review of hospital quality. It accredits about 80 percent of the hospitals in the country and, for Medicare purposes, it has a congressionally granted deeming status that is unique among accrediting bodies. Medicare beneficiaries and others who rely upon hospital services have much at stake in how and how well the Joint Commission does its job.

Our review underscores that the core element of the Joint Commission's approach to accreditation is the announced, on-site survey of hospitals--a survey that is heavily oriented toward educational and performance improvement objectives. The other elements of external review--unannounced surveys, responses to complaints and serious incidents, and standardized performance measures--play relatively minor roles in the Joint Commission's accreditation process.

Given the significance of the Joint Commission's role and its emphasis on one approach to external quality review, our inquiry surfaces important policy questions for HCFA: How can it best ensure an appropriate balance in external quality reviews of hospitals? How can it best hold the Joint Commission accountable for the important public role it performs while enabling it, at the same time, to have enough flexibility to continue to advance the state-of-the-art of hospital accreditation? We address these questions in our summary report, *A Call for Greater Accountability*. That report also contains our recommendations, which we direct to HCFA.

Medicare Conditions of Participation

The Medicare Conditions of Participation (COP) were first published in 1966 and revised in 1986 (42 C.F.R. 482.1-482.66). On December 19, 1997, HCFA published a proposed COP for hospitals (62 Fed. Reg. 66,726). On July 2, 1999, it published an interim final rule on patients’ rights (64 Fed. Reg. 36,070). Below are the components of the existing COP for non-specialty hospitals from 1986, followed by the components of the new proposed COP.

Existing COP	Proposed COP
Subpart A- General Provisions	Subpart A- General Provisions
Provision of emergency services by nonparticipating hospitals	Patient Rights (issued as an interim final rule on July 7, 1999)
Subpart B- Administration	Subpart B- Patient Care Activities
Compliance with Federal, State, and local laws Governing Body	Patient Admissions, assessment, and plan of care Patient care Quality assessment and performance improvement Diagnostic and therapeutic services or rehabilitation services Pharmaceutical services Nutritional services Surgical and anesthesia services Emergency services Discharge Planning
Subpart C- Basic Hospital Functions	Subpart C- Organizational Environment
Quality assurance Medical staff Nursing services Medical record services Pharmaceutical services Radiologic services Laboratory services Food and dietetic services Utilization review Physical environment Infection control	Administration of organizational environment Infection control Human resources Physical environment Life safety from fire Blood and blood products transfusions Potentially infectious blood and blood products Utilization review
Subpart D- Optional Hospital Services	
Surgical services Anesthesia services Nuclear medicine services Outpatient services Emergency services Rehabilitation services Respiratory care services	

Methodology

We collected information presented in this report from the following sources:

The HCFA

We obtained dates of certification surveys from HCFA's Online Survey Certification and Reporting System (OSCAR). The HCFA authorizes States to update and maintain this database with survey information. We extracted survey data pertaining to the frequency of certification surveys. We subsequently verified the accuracy of our extraction by comparing it to on-line OSCAR system information to ensure the dates we used corresponded to routine certification surveys, rather than complaint investigations or other types of surveys. We are satisfied that our information is as accurate as HCFA's OSCAR system.

Additionally, we selected 4 States (California, Kansas, Minnesota, and Texas) that contain over 50 nonaccredited hospitals and represented different geographic regions of the United States. We then examined the OSCAR data for those States in greater detail. We verified the operational status of the nonaccredited hospitals in those States that had not been surveyed in over 5 years using the American Hospital Association's *1997 Hospital Guide*.

We also interviewed staff and managers at each HCFA regional office and the central office. We reviewed a variety of HCFA documents, including budget call letters, reinvention materials, and reports to Congress, among others.

The State Survey and Certification Agencies

In August 1997, we mailed a pretested survey to the hospital certification agencies in the 50 States and the District of Columbia. The response rate for this survey was 100 percent. The State survey addressed four areas of hospital quality oversight: private accreditation of hospitals, Medicare certification of hospitals, HCFA oversight of State certification agencies, and State licensure of hospitals. We interviewed State officials on the telephone or in person as well.

Accrediting Organizations

We interviewed officials from both the Joint Commission on Accreditation of Healthcare Organizations and the American Osteopathic Association. We also reviewed

documents such as mission statements, accreditation manuals, policies, and hospital survey files. We requested and received aggregate data from the Joint Commission reflecting its recent hospital survey activity. All Joint Commission data are presented as reported by the Joint Commission, unless otherwise noted. For purposes of this inquiry, we focused our analysis on the Joint Commission.

Survey Observations

Based on schedules of upcoming triennial surveys, we identified nine hospitals in which to observe triennial Joint Commission surveys. Of those, we were able to observe seven. In two cases, the hospitals declined the Joint Commission's request that we be allowed to observe. The 7 hospitals varied in size from 80 to 775 beds, represented both teaching and community hospitals, and were located in different areas of the country (both rural and urban). We also observed one random unannounced Joint Commission survey. Although we observed different teams of surveyors, the survey agenda, lines of inquiry, and tone were consistent across the surveys, which were conducted in accordance with Joint Commission policy, based on review of survey manuals and interviews with representatives of the Joint Commission. Finally, we observed a certification survey and parts of two complaint investigations performed by State surveyors under HCFA's auspices.

Stakeholder Interviews

We interviewed representatives of organizations we considered to be stakeholders in hospital oversight. These stakeholder organizations included a union, professional organizations, hospital associations, and consumer groups.

Other Documents

In addition to the documents referenced above, we reviewed statutory and regulatory language and a variety of articles from newspapers, journals, magazines, and newsletters.

Sample Accreditation Survey Agenda

We took the following sample agenda from the Joint Commission's web page (http://www.jcaho.org/acr_info). This agenda is representative of the agendas surveyors followed when we observed accreditation surveys.

Sample Generic Survey Agenda: Three-Day Survey/Three Surveyors

In most instances, the survey team is composed of an administrator, nurse, and physician. In smaller hospitals, the survey team includes two surveyors, usually a nurse and a physician.

Day One:

All Surveyors:

- 8:30-8:45 am Opening Conference
- 8:45-9:15 am Performance Improvement Overview Presentation
- 9:15-11:00 am Document Review Session
- 11:00-11:45 am Leadership Interview
- 11:45-12:15 pm Lunch

Physician Surveyor:

- 12:30-2:00 pm Patient Care Setting Visit (Includes inpatient units and other sites where care is provided, including ambulatory settings and anesthetizing locations.)
- 2:00-3:00 pm Anesthetizing Location Visit (Includes inpatient units and other sites where care is provided, including ambulatory settings and anesthetizing locations.)
- 3:00-4:00 pm Emergency Services Visit

Nurse Surveyor:

- 12:30-2:00 pm Patient Care Setting Visit (Includes inpatient units and other sites where care is provided, including ambulatory settings and anesthetizing locations.)
- 2:00-3:00 pm Anesthetizing Location Visit (Includes inpatient units and other site where care is provided, including ambulatory settings and anesthetizing locations.)
- 3:00-4:00 pm Patient Care Setting Visit (Includes inpatient units and other sites where care is provided, including ambulatory settings and anesthetizing locations.)

Administrator Surveyor:

- 12:30-1:15 pm Rehabilitation Services Visit

1:15-4:00 pm Building Tour (Includes visits to admitting, kitchen, resource center, storage, central supply, and laundry, if applicable.)

All Surveyors:

4:00-4:30 pm Survey Team Meeting

Day Two:

All Surveyors:

8:15-8:45 am Daily Briefing

Physician Surveyor:

8:45-9:45 am Pathology and Clinical Laboratory Services Visit (Includes survey of blood and blood components.)

9:45-10:45 am Medical Staff Credentials Interview

10:45-11:45 am Medical Staff Leadership Interview

11:45 am-12:45 pm Lunch: Medical Staff Conference (Optional)

Nurse Surveyor:

8:45-10:00 am Patient Care Setting Visit (Includes inpatient units and other sites where care is provided, including ambulatory settings, and anesthetizing locations.)

10:00-10:45 am Patient Care Setting Visit (Includes inpatient units and other sites where care is provided, including ambulatory settings, and anesthetizing locations.)

10:45-11:30 am Infection Control Interview

11:30 am-12:15 pm Nursing Leadership Interview

Administrator Surveyor:

8:45-9:30 am Patient Care Setting Visit (Includes inpatient units and other sites where care is provided, including ambulatory settings, and anesthetizing locations.)

9:30-10:15 am Hospital Department Directors Interview

10:15 am-12:15 pm Review of Environment of Care Documents

Nurse and Administrator Surveyors:

12:15-12:45 pm Lunch

Administrator Surveyor :

1:00-1:45 pm Chief Executive Officer/Strategic Planning and Resource Allocation Interview (Includes Ethics Interview issues.)

1:45-2:15 pm Pharmacy Services Visit

Physician and Nurse Surveyors:

1:00-2:00 pm Medical Record Interview

Physician Surveyor:

2:00-2:45 pm Patient Care Setting Visit (Includes inpatient units and other sites where care is provided, including ambulatory settings, and anesthetizing locations.)

2:45-4:00 pm Imaging Services Interview

Nurse and Administrator Surveyors:

3:00-4:00 pm Human Resources Interview

All Surveyors:

4:00-4:30 pm Survey Team Meeting

Day Three:**All Surveyors:**

8:15-8:45 am Daily Briefing

8:45-9:45 am Patient Care Interview

Physician Surveyor:

9:45-10:30 am Performance Improvement Team Interview

Nurse Surveyor:

9:45-10:30 am Performance Improvement Team Interview

Administrator Surveyor:

10:00-11:00 am Information Management Interview

All Surveyors:

10:30-11:30 pm Performance Improvement Coordinating Group Interview

11:30-12:00 pm Lunch

12:00-3:00 pm Team Meeting to Integrate Survey Findings

3:15-4:15 pm Leadership Exit Conference

Advertising Hospital Accreditation Status

During the course of our inquiry, we saw a range of advertisements extolling hospital's accreditation status.¹ We saw advertisements in newspapers, magazines, fund-raising materials, yellowpages, and on billboards and the Internet. We also saw a banner strung prominently outside a hospital. Most touted the hospital's achievement of accreditation with commendation. For example, one advertisement from a web page included the following:

Accreditation is the way hospitals are judged. Commendation is how they are judged superior...We're proud to be recognized as one of the best hospitals...in the country...Our accreditation with commendation puts [us] in the upper 10% of all hospitals surveyed in the past 3 years.

Another ad, this one from a magazine, pitched a hospital chain and its accreditation as follows:

As for quality, the Joint Commission on the Accreditation of Healthcare organizations, an independent group that reviews staffing, safety and patient care at hospitals around the country, recognizes [our] hospitals with its highest ratings: Accreditation with Commendation, at a rate three times the national average.

Yet another, from a newspaper noted:

Accreditation with Commendation. It's the highest level of achievement awarded by the Joint Commission on the Accreditation of Healthcare Organizations. And a distinction earned by only 4 percent of hospitals nationwide.

¹The Joint Commission issues guidelines on how hospitals can characterize their accreditation status in such ads and considers false or misleading advertising of accreditation as grounds for denying accreditation (Joint Commission on Accreditation of Healthcare Organizations, *Comprehensive Accreditation Manual for Hospitals*, 1997, p AC-18).

Endnotes

1. Troyen A. Brennan et al, "Incidence of Adverse Events and Negligence in Hospitalized Patients," *The New England Journal of Medicine* 324 (February 7, 1991) 6: 370-376.

2. The 17.7 percent refers to adverse events considered by the authors to be serious. The authors defined adverse events as "situations in which an inappropriate decision was made when, at the time, an appropriate alternative could have been chosen" and serious as ranging from "temporary disability to death." See Lori B. Andrews et al, "An Alternative Strategy for Studying Adverse Events in Medical Care," *The Lancet* 349 (February 1, 1997)309-313.

See also Lucian L. Leape, "Error in Medicine," *Journal of the American Medical Association* 272 (December 21, 1994) 23: 1851-1857; David C. Classes et al, "Adverse Drug Events in Hospitalized Patients," *Journal of the American Medical Association* 277 (January 22/29, 1997) 4: 301-306; Mark R. Chassin et al, "The Urgent Need to Improve Health Care Quality: Institute of Medicine National Roundtable on Health Care Quality," *Journal of the American Medical Association* 280 (September 16, 1998) 11: 1000-1005; David W. Bates et al, "Effect of Computerized Physician Order Entry and a Team Intervention on Prevention of Serious Medication Errors," *Journal of the American Medical Association* 280 (October 21, 1998) 1311-1316; Robert A. Raschke et al, "A Computer Alert System to prevent Injury from Adverse Drug Events: Development and Evaluation in a Community Teaching Hospital," *Journal of the American Medical Association* 280 (October 21, 1998) 1317-1320; and David C. Classen, "Clinical Decision Support Systems to Improve Clinical Practice and Quality of Care," *Journal of the American Medical Association* 280 (October 21, 1998) 1360-1361.

3. One example is a November 1998 *New York Times* article under the headline: "Death in Surgery Reveals Troubled Practice and Lax Hospital." The article described a "botched" operation on a young woman by a surgeon who was on probation by the State medical board and who used unauthorized medical equipment brought in to the operating room by a medical supply salesman. Such incidents can happen even in the best of hospitals, but they underscore the point that hospitals can be dangerous places and that oversight systems can be lax. See also "Overdoses Still Weigh heavily at Dana Farber," *The Boston Globe* (26 December 1995); "Florida Doctor Sanctioned in New Amputation," *The Boston Globe* (19 July 1995); "Two Surgeons Surrender Licenses After Mistakenly Removing Kidney," *The Boston Globe* (6 June 1996); "How Can We Save the Next Victim?" *New York Times Magazine* (15 June 1997); "Another Hospital Death Probed," *The Boston Globe* (26 July 1997); "Patient Dies After Drinking Poison Left on Nightstand," *San Diego Union-Tribune* (6 March 1998); "Man Arrested for Posing as Doctor for 4 years," posted at the CNN interactive webpage (16 May 1998); "Deadly Restraint: Patients Suffer in a System Without Oversight," *The Hartford Courant* (13 October 1998).

4. <http://WWW.hcfa.gov/Medicare/Medicare.htm>
5. Ibid.
6. Ibid.
7. P.L. 89-97.
8. The HCFA published its proposed hospital conditions of participation on December 19, 1997 (62 Fed. Reg. 66,726). On July 2, 1999, it published an interim final rule concerning patients' rights (64 Fed. Reg. 36070).
9. Social Security Act, sec. 1865, 42 U.S.C 1395bb.
10. Health Care Financing Administration, OSCAR 10 Report, as of May 30, 1998.
11. Michael S. Hamm, *The Fundamentals of Accreditation* (Washington, D.C.: American Society of Association Executives, 1997) 3.
12. Ibid.
13. Nonaccredited hospitals can go through the Medicare certification process for free.
14. Although we conducted some interviews with staff from the American Osteopathic Association, another hospital accrediting body, we decided to exclude it from our inquiry. Our decision was based on our own time and resource constraints. We may examine accreditation through the American Osteopathic Association in a future inspection.
15. In some cases, the surveyors will identify a type of record (e.g., a patient with recent restraint orders or a personnel file of a respiratory therapist) or will request that a particular staff person's personnel file be pulled.
16. The building tour and document review sessions take longer. The unscheduled time built into the structure is generally in 15-minute blocks. We observed surveyors often use that time for telephone calls, further document review, or as a buffer in case other sessions ran over.
17. Indeed, even the likely focus of the surveys or surveyors is available to those hospitals looking for it. For example, hospitals can purchase individual surveyor profiles through an internet site or visit chat rooms to exchange details on recent surveys. One surveyor told us he casually mentioned liking chocolate chip cookies at one hospital, and was thereafter inundated with them--an occurrence he attributed to these web sites and chat rooms. Hospitals can also subscribe to

newsletters that track the latest trends and focus of Joint Commission surveys.

18. Surveyor notes to the Joint Commission found in the Joint Commission files.
19. The Joint Commission changed its standards as part of their “Agenda for Change”, an initiative calling for a more performance-based accreditation process which was unveiled in 1986.
20. Dennis O’Leary, “President’s Column: On Becoming Ten,” *Joint Commission Perspectives*, 16 (May/June 1996) 3: 2-3.
21. “The accreditation process itself is fundamentally a risk-reduction exercise. We don’t warrant outcomes or that nothing bad will ever happen. We’d be crazy to do that because you can never take the level of risk down to zero” (Dennis O’Leary, quoted in *Setting Standards for Hospitals: An Interview with Dennis O’Leary in The Long Term View* 3 (4) 23).
22. In 1995, the Joint Commission launched an experiment in a more continuous accreditation process, called the Orion Project. Operating in four States (Arizona, Pennsylvania, Georgia, and Tennessee), the Orion Project involves partial surveys conducted quarterly by the same surveyors for participating hospitals.
23. In early 1997, the Executive Committee of the Board of Commissioners approved an interim cap on the scores of three standards related to restraints.
24. Data as reported by the Joint Commission.
25. The most frequently cited deficiencies are often identified in newsletters such as “Inside the Joint Commission” and “Joint Commission Perspectives.”
26. <http://jcaho.org>.
27. Continuous Quality Improvement is a method of performance improvement involving a continuous loop of performance measurement, intervention, and remeasurement. It aims to improve the majority rather than marginal performers. D. E. Berwick, “Continuous Quality Improvement as an Ideal in Health Care,” *New England Journal of Medicine* 320 (January 5, 1989) 1: 53-56; The Institute of Medicine, *Medicare: A Strategy for Quality Assurance* (Washington, D.C.: National Academy Press, 1990).
28. Joint Commission on Accreditation of Healthcare Organizations, “Understanding the 1997 Hospital Performance Report,” 4.

29. In response to the unexpected deaths, the Joint Commission conducted a special announced survey lasting one day, during which the hospital presented its analysis of the cause and the surveyor identified four deficiencies regarding assessing patients and assessing competence.

30. Joint Commission on Accreditation of Healthcare Organizations, “Understanding the 1997 Hospital Performance Report,” 10, and “1997 Performance Report,” ii.

31. According to data reported by the Joint Commission, the most commonly identified deficiencies in credentialing between May 1995 and June 1997 were related to the inclusion of pending or successful challenges to licensure, relinquishment of licensure, criteria for autopsies, and primary verification of license, experience, training, and competencies.

While we found no examples of surveyor probing to ensure that hospitals deal fully and responsibly with marginal performers, we did observe one medical leadership session where the physician surveyor gave a stern message about the significance of credentialing and privileging decisions. He said that the standard that physician reviewers should use in making such decisions about their colleagues was “The Mom Test.” “Would you feel comfortable,” he asked, “in having the colleague care for your mother?” Someday, he warned the assembled physicians, “you will be walking or taken through hospital doors as a patient and you will be dependent on the conscientiousness and skill of the medical staff at that hospital. Think about it.”

32. In a 1995 Office of Inspector General report, we found that 75 percent of the hospitals in the country never reported an adverse action to the Data Bank between September 1, 1990 and December 31, 1993 (Office of Inspector General, *Hospital Reporting to the National Practitioner Data Bank*, February 1995).

33. In December 1994, the Joint Commission began releasing accreditation information about hospitals, on request, in the form of performance reports. These reports include the hospital’s overall survey score from the last triennial survey, the hospital’s scores in the 45 performance areas surveyed, comparative data on the percentage of hospitals receiving each possible score in the 45 performance areas, and a list of the performance areas in which the hospital received deficiencies. In November 1996, the Joint Commission waived the \$30 report fee.

As of late 1998, 13,408 performance reports for hospitals, nursing homes, and other provider types were available, and that list keeps growing. Between late 1996 and early 1997, requests for performance reports grew from 13 per quarter to over 2,000. Beginning in early 1998, the Joint Commission made the reports available on its website, and since then requests for reports have tapered off, suggesting some are accessing the information directly through the website rather than ordering reports.

34. The Joint Commission allows hospitals to be accredited as single entities or, if they are a part of a multi-hospital system, to be accredited through a system survey. The multi-hospital option includes a corporate orientation and/or a corporate summation in addition to a consecutive survey of the system's hospitals with the same survey team. The Joint Commission charges an extra fee for this option. The Joint Commission also offers network accreditation, so hospitals that are part of a particular health care network could also be surveyed under the auspices of a network survey--in addition to their own hospital survey. The Joint Commission could award a different accreditation status to the hospital than to the network, making it difficult for consumers to discern the meaning of each.

35. Some Joint Commission scoring guidelines are based on algorithms

36. The levels of accreditation are: accreditation with commendation, accreditation without type 1 recommendations, accreditation with type 1 recommendations, conditional accreditation, and preliminary nonaccreditation. Preliminary nonaccreditation is generally considered to be a temporary status.

From June 1995 through May 1998, the Joint Commission awarded accreditation with commendation to hospitals surveyed as a part of a hospital system much more often (22 percent) as hospitals surveyed as single entities (13 percent). Achieving any accreditation level qualifies a hospital to participate in Medicare. By contrast, the National Committee for Quality Assurance, which accredits health plans, has used four accreditation levels. Eleven percent of plans met its lowest, or provisional level, and 11 percent were denied accreditation. Unlike Joint Commission hospital accreditation, Congress has not deemed the National Committee for Quality Assurance (NCQA) accreditation for purposes of participating in Medicare. We extracted the data on NCQA accreditation from its web page, "NCQA Accreditation Status List: A Fact Sheet" (<http://www.ncqa.org>).

37. When the Joint Commission identifies a Type 1 recommendation in a hospital, that hospital must either submit a written progress report and/or be subject to a focused survey. Written progress reports far exceed focused surveys as a form of follow-up: between June 1995 and May 1998, the Joint Commission called for 3,264 written progress reports and 417 focused surveys. Between June 1995 and May 1997, the Joint Commission rejected about 2 percent of written progress reports for triennial surveys and required an additional follow-up, usually an on-site survey, for those hospitals. Of course, the Joint Commission can call for multiple written progress reports and focused surveys from a single hospital, depending on the particular situation. Hospitals accredited with commendation are subject to no such follow-up, but could be selected for a random, unannounced survey.

38. The Joint Commission allows hospitals the opportunity to improve their scores by correcting problems identified in the survey (also referred to as type 1 recommendations). It conducts two kinds of follow-up to ensure the hospitals have made the appropriate corrections: written progress reports and focused surveys.

About a fourth of all hospitals' scores improved on average 1 point after they addressed their deficiencies; the others remained the same or went down. From June 1995 to May 1996, hospital scores averaged 91 (for multi-hospital option) and 90 (for single hospital option). From June 1996 to May 1997, hospital scores averaged 93 (for multi-hospital option) and 91 (for single hospital option).

39. Joint Commission on Accreditation of Healthcare Organizations, 1997 Performance Report, p. 3.

40. In addition, the Joint Commission uses written progress reports and focused surveys both to ensure hospitals address deficiencies and as a way to monitor continued compliance. Written progress reports and focused surveys are considered follow-up actions to Joint Commission surveys. It also uses unannounced and unscheduled surveys to respond to concerns about patient safety in a hospital, which are discussed in the section on "Responding to Complaints."

41. "Raid of Hospitals Probes Overworked Doctors," *The Wall Street Journal* (11 March 1998); "Inspectors Pay Surprise Visits to 12 New York Hospitals," *The New York Times* (12 May 1998).

42. State agencies do, however, give notice to hospitals prior to conducting validation and certification surveys.

43. 42 USC 1819(g)(2).

44. David R. Morrow, "To Rate Hospitals, She Dons a Wig and Practices Her Cough," *New York Times*, Sunday, 30 March 1997.

45. Following are some illustrations of newspaper reports on serious incidents involving patient harm: "Florida Doctor Errs Anew, Taking Toe Without Asking," *The New York Times*, July 19, 1995; Lawrence K. Altman, "State Issues Scathing Report on Error at Sloan-Kettering," *The New York Times*, November 16, 1995; Richard Saltus, "Patient's Death Leads to Change at the Brigham," *The Boston Globe*, February 16, 1996; Richard Saltus, "Two Surgeons Surrender Licenses after Mistakenly Removing Kidney," *The Boston Globe*, June 6, 1996; and "Death in Surgery Reveals Troubled Practice and Lax Hospital," *The New York Times* (15 November 1998).

46. The Commission typically conducted these investigations on its own, independent of any investigations being conducted by State and/or HCFA officials.
47. The Joint Commission refers to this as a “root-cause analysis.”
48. For articles supporting and or explaining this approach to medical errors, see Lucian L. Leape, “Error in Medicine,” *The Journal of the American Medical Association* 272 (December 21, 1994) 23:1851-57; Lucian L. Leape, et al, “Systems Analysis of Adverse Drug Events,” *The Journal of the American Medical Association* 274 (July 5, 1995) 1:35-43; David W. Bates, “Incidence of Adverse Drug Events and Potential Adverse Drug Events,” *The Journal of the American Medical Association*, 274 (July 5, 1995) 1:29-34; Lawrence K. Altman, “Medical Errors Bring Calls for Change,” *The New York Times*, July 18, 1995; Linda O. Praeger, “Reducing Medical Errors,” *American Medical News* 39 (November 4, 1996) 41; Denise Grady, “Doctors Urged to Admit Mistakes,” *The New York Times*, December 9, 1997; and Lucian L. Leape et al, “Promoting Patient Safety by Preventing Medical Error,” *The Journal of the American Medical Association* 280 (October 28, 1998) 16: 1444-1447.
49. The Joint Commission’s policy calls for a hospital voluntarily to notify it of a reportable major adverse event within 5 business days and subsequently to conduct an acceptable analysis of the event’s cause within 30 days.
50. In this respect, the Joint Commission indicates that its approach is similar to the aviation accident and incident reporting system of the National Transportation Safety Board. See http://nasdac.faa.gov/safety_data/.
51. During this period, the Joint Commission has drawn on its sentinel event database to issue four alerts with specific risk reduction strategies for hospitals. The first, issued on February 27, 1998, focused on preventing medication errors and involved the misadministration of potassium chloride. The second, issued August 28, 1998, was on wrong-site surgery. The third and fourth were both issued in November 1998 and dealt with preventing inpatient suicides and restraint deaths. (See Joint Commission on Accreditation of Healthcare Organizations, *Sentinel Event Alert*, February 27, 1998; August 28, 1998; November 6, 1998; and November 18, 1998.)
52. “Joint Commission Statement on the Revised Sentinel Event Policy,” February 17, 1998.
53. Further, if the public recognizes that the Joint Commission rarely changes a hospital’s accreditation status as a result of a adverse event, the public is likely to increasingly view the Joint Commission as being soft on hospitals at the expense of public safety. The Joint Commission itself is aware of this danger. In a column in its own newsletter, the Joint Commission’s president noted that while hospitals tend to regard such events as their own business, “those speaking on

behalf of the public see sentinel event identification and follow-up as central to the Joint Commission's role, and credibility, as an accrediting body." For hospitals wary even of the gentler Joint Commission policy toward such events, he cautioned, "[I]n the end, the Joint Commission may be the one constructive force standing between the organization that has experienced a sentinel event and society's handmaidens of punishment." He did not identify the latter. See Dennis S. O'Leary, "President's Column: The Sentinel Event Policy: A Work in Progress," *Joint Commission Perspectives*, November/December 1996, pp. 2-3.

54. Despite occasional newspaper articles, how aware consumers are of the Joint Commission remains unknown ("Before You Go Into the Hospital," *Parade Magazine*, 4 May 1997, 6-8). Consumers may be more aware of their State governments or HCFA as places to file complaints. When we asked stakeholders the extent to which they expected accreditation to play a role in responding to complaints, their responses were mixed: about a third (34 percent) expected no or a minor role; 18 percent, a moderate role and; nearly half (48 percent), at least a great role.

55. Reflects data as reported by the Joint Commission. However, based on our file review, the public information interviews may be undercounted to some extent. We reviewed the Joint Commission's hospital files for the seven surveys we observed, of which four had public information interviews. We found no record of the four public information interviews we observed in the files.

56. The most recent data available from the Joint Commission indicates that surveyors conducted 31 public information interviews during the first 6 months of 1998, involving about 4 percent of surveys conducted during that time. Five of the 31 (16 percent) resulted in type 1 recommendations.

57. In 1996, for example, it reported receiving 2,718 complaints (43 percent by mail and 57 percent by telephone), a 3.5 percent decrease from those it received in 1995. Twenty-seven percent of the written complaints were either unrelated to an accredited hospital or unintelligible, thus prompting no further action from the Joint Commission. But the Joint Commission tracked 30 percent of the written complaints for trends and sent 27 percent to surveyors for triennial or focused surveys.

58. Joint Commission on Accreditation of Healthcare Organizations, March 3, 1999. The Joint Commission also accepts complaints by electronic mail, fax, and mail.

59. In the 3-year period from June 1995 through May 1998, 17 percent of the unscheduled and unannounced surveys resulted in a change in the hospital's accreditation status and 50 percent resulted in some follow-up (involving focused surveys and/or written progress reports).

60. On its webpage (<http://www.jcaho.org>), the Joint Commission identifies the following ways that integrating performance measures will “enhance the value of accreditation:

- *increase public and private sector reliance on Joint Commission accreditation, thereby building support for the consensus development and use of standards and performance measures, as well as reducing justification for duplicative evaluation activities;*
- *provide the Joint Commission with performance data that it can use to*
 - *monitor organization performance on a continuous basis,*
 - *help organizations identify issues that require attention, and*
 - *focus triennial surveys on areas within an organization that represent the greatest potential opportunities for improvement;*
- *help identify both exemplary performance and best practices to facilitate the provision of benchmarking services to health care organizations; and*
- *facilitate refinement of the Joint Commission’s performance-based standards and the analysis and understanding of the relationships between standards and outcomes.”*

61. Christina Kent, “‘Fix it or forget it’: The JCAHO in Crisis,” *Medicine & Health* (January 23, 1995).

62. The Joint Commission regularly reviews performance measurement systems, so new systems found to meet its minimum requirements can be added to the list. The Joint Commission also can remove approved systems. (<http://www.jcaho.org/perfmeas/>).

63. On March 15, 1999, the Joint Commission invited accredited institutions, physicians, universities, consumer groups, and researchers, among others, to identify and prioritize potential areas for it to develop core measures.

64. American Hospital Association to Joint Commission on Accreditation of Healthcare Organizations, January 5, 1999.

65. Ibid.

66. J. Duncan Moore, Jr., “Standardizing Standards: Accrediting agencies form council to end confusion,” *Modern Healthcare* (May 25, 1998); “Three for Quality,” *American Medical News* (June 15-22, 1998); “Three Accreditation Groups to Collaborate on Standard Approach to Quality Measures,” *BNA’s Managed Care Reporter* (May 27, 1998).